



Navy Executive Safety Board (NESB) Flag Panel Meeting

27 June 2006



Agenda

- **1400-1405:** **WELCOME - VCNO/COMNAVSAFECEN**
- **OLD BUSINESS**
- **1405-1420:** **BRIEF: NAVY PMV MISHAP INVESTIGATIONS AND ROOT CAUSE (BRIEFER: NAVSAFECEN)**
- **1420-1435:** **NESB DISCUSSION**
- **1435-1445:** **BRIEF: ORM WAY AHEAD (BRIEFER: NAVSAFECEN)**
- **1445-1455:** **NESB DISCUSSION**



Agenda

(continued)

- **1455-1500: BRIEF: TRACKING DON CIVILIAN MISHAPS (BRIEFER: NAVSAFECEN)**
 - **1500-1505: BRIEF: NAVY POA&M UPDATE (BRIEFER: NAVSAFECEN)**
 - **1505-1515: NESB DISCUSSION**
- NEW BUSINESS**
- **1515-1530: BRIEF: 2006 DON OBJECTIVES (BRIEFER: ODASN(S))**
 - **1530-1540: BRIEF: NAVY FY06 MISHAP TOTALS (BRIEFER: NAVSAFECEN)**
 - **1540-1555: NESB DISCUSSION**
 - **1555: CLOSING COMMENTS - VCNO**



SECDEF memo of 22 Jun 06: Reducing Preventable Accidents

I have set some very specific mishap reduction goals for the Department to achieve. My congratulations to those who are progressing toward their respective goals, but others are not. We must rededicate ourselves to those goals - and achieve them.

Too often we excuse mishaps by citing the difficult circumstances in which we operate. We have trained our men and women to operate safely in very trying conditions. There is no excuse for losing lives given proper planning, attention to detail, and the active involvement of the chain of command.

Accountability is essential to effective leadership. I expect all the Department's leaders, from the Commander to the first line supervisors, to be accountable for mishaps under their watch. We simply will not accept status quo.

If we need to change our training, improve our material acquisition, or alter our business practices to save the precious lives of our men and women, we will do it. We will fund as a first priority those technologies and devices that will save lives and equipment. We will retrofit existing systems, and consider these devices as a "must fund" priority for all new systems. We can no longer consider safety as "nice-to-have."

I want to hear what you are doing to improve your safety performance and I want to see the results of your actions.



Old Business



Navy PMV mishap investigations & root cause analysis



NESB Tasking

Task #1: Review the PMV investigation programs of the Army and the Air Force and develop recommended changes to the Navy's methodology for PMV mishap investigations.

Task #2: Develop the methodology necessary to conduct root cause analysis of PMV mishaps. Make recommendations for programmatic changes to implement the methodology



Methodology

- **STEP 1: Define root cause analysis**
- **STEP 2: Review PMV investigation process for Army and Air Force to determine if root cause analysis is being utilized**
- **STEP 3: Current status of Navy PMV investigations**
- **STEP 4: Navy PMV investigation process change recommendations/way ahead**



Root Cause Analysis definition

Root Cause Analysis (RCA) Definition

- A structured evaluation method that identifies the root causes for an undesired outcome and the actions adequate to prevent recurrence.
- Root cause analysis should continue until organizational factors have been identified, or until data are exhausted.
- RCA is a method that helps professionals determine:
 - What happened
 - How it happened
 - Why it happened
- Allows learning from past problems, failures, and mishaps.



Root Cause Analysis information

Steps in Root Cause Analysis:

- Clearly define the undesired outcome.
- Gather data, including a list of all potential causes.
- Continue asking “why” to identify root causes.
- Check your logic and eliminate items that are not causes.
- Generate solutions that address both proximate causes and root causes.



PMV Investigation Process

Army: Combat Readiness Center investigates selected off-duty PMV mishaps based on availability of investigators and whether mishap is high-vis

- Two 2-man teams (plan for four 2-man teams)
- Has investigated 8 of 80 mishaps this FY

Air Force: Convening authority for off-duty Class A and B motor vehicle assigns investigator from the commander of the nearest installation with a full-time safety manager, unless MAJCOM commander elects to assume investigative responsibility

- Has investigated all 31 mishaps this FY
- Process similar to Navy, relies on local police report

Conclusion: Neither the Army nor the Air Force current investigation processes determine root cause(s)



Current Navy PMV Investigation Process

NAVY INVESTIGATION PROCESS:

- Navy utilizes Investigation, Reporting, and Record Keeping Manual OPNAVINST 5102.1D for PMV Investigations

KEY POINTS:

- Unit Level Command notifies COMNAVSAFECEN within 8 hours of incident
- Unit Level Commander appoints a Unit Level Safety Investigator
- First Flag Notification within 7 days of the mishap
- Safety Investigation Report submitted by unit level within 30 days via WESS or SIREP Message
- IAW OPNAVINST 5102.1D Safety Investigation Board (SIB) is optional for PMV mishaps:
 - CNO (NO9F) may initiate an independent safety investigation.
 - Any Mishap that a controlling command determines requires a more thorough investigation and report.



Navy PMV Investigation Summary

CONCLUSIONS:

- **NAVY Unit Level PMV Mishap Investigations are limited in scope**
 - **Examples of items not always considered:**
 - Command Traffic Safety Training
 - Command Mentorship Program
 - Available Command Traffic Tools
 - Command PMV Special Liberty/Leave Policy
 - Command “Drive Alive”/“Tipsy Taxi”/“Safe Ride” Program
 - Drive Safe Incentives



Root Cause Analysis Tool

- Looked at software tool **REASON** recommended by NAVAIR
 - Navy Safety Center visited NAVAIR 24 May 2006
 - Software company provided software demo at Naval Safety Center 14 June 2006 utilizing an existing PMV Safety Investigation Report
- Naval Safety Center believes **REASON** shows great promise and should be studied further to fully assess its value as a PMV investigation tool.



Possible Ways Ahead

- **Improve Data Collection**
 - **Require an investigation of all Class A PMV**
 - **Stand up of Safety Investigation Board (SIB)**
 - Command/Region/Naval Safety Center
- **Improve Root Cause Analysis**
 - **Use PMV Mishap Investigation Template**
 - **Needs to be fully vetted with stakeholders**
 - **Investigate software solution for Root Cause Analysis**
 - **REASON**



NESB Discussion



Back up slides

- **FY06 (Oct-Mar) PMV fatalities data shortfall:**
 - **72 Hour Profile**
 - 17 complete**
 - 16 incomplete**
 - 10 partials**
 - 4 No final report received**
 - **Total FY06 Fatalities 47**

72 Hour Profile alone cannot determine root cause



Back up slides

- **US Army CRC PMV Investigation Teams**

- Currently - Two 2-person teams**

- **One GS (Senior Member) & One Contractor (recorder) per team**
 - **8 Investigations this FY**

- Future - Four 2-person teams**

- **Hiring 2 additional GS positions now**
 - **Will contract for 2 additional recorders near term**
 - **Anticipate conducting 40 investigations per year**
 - **10 investigations per team**
 - **2 weeks conducting investigation and 2 weeks in office completing required reports**



Back up slides

Unit Level Safety Investigation Report data short comings:

Off-duty Class “A” PMV Organizational Causes overlooked:

- Command DAPA Program
- Command Traffic Safety Training
- Command Mentorship Program
- Chain of Command Interviews
- Member Service Record (Evals, PG 13s, waivers)
- Available Command Traffic Tools
- Command PMV Special Liberty/Leave Policy
- Driving Record
- 72 hour profile
- Command “Drive Alive”/“Tipsy Taxi”/“Safe Ride” Program
- Command MWR Activities
- Drive Safe Incentives (Special lib, days off. Eval point system)



ORM

**Managing Risk for Operational
Excellence:
The Navy's Revitalization Effort**

ESB Update - 27 June 2006



ORM Way Ahead

**Task: Provide a way ahead on
Risk Management.**



Overview

- **Hazards - Threats to the ORM Revitalization**
- **Controls - Execution Strategies**
 - Leadership - Requirements and requests
 - Education - What is underway and what is planned
 - Assessment - Trials and engaged organizations
 - Feedback - Ongoing and planned
- **Supervision - ORM Organization and Responsibilities**



Hazards to the Effort

- **Wide Variations in Fleet Knowledge and Application**
 - Some commands very well integrated and visible
 - Some commands no integration at all
 - Some commands don't know what they don't know
 - **Risk Assessment:** Probability - high, severity - Could prevent fleet wide acceptance
- **Lack of Standard Terminology Use**
 - A key to our success
 - Where ORM application is apparent to the trained ear and eye, it is invisible due to lack of term usage and practice standardization
 - **Risk Assessment:** Probability - certain, severity - keeps efforts invisible and prevents unit wide usage



Controls

Leadership

- **Center for Naval Leadership Engagement**
 - Building into Leadership Continuum
 - Incorporating into 360 Assessment project
- **Messages to the Fleet**
 - Continuously reinforce leadership commitment
 - Demonstrate understanding and terminology use



Controls

Education and Training

- Continue building Safety Training Continuum
 - Majority of resources focused here
 - Fundamental knowledge - practical reinforcement
 - METC/NPDC/NSTC engaged in development
- Current Areas of Focus
 - Unit level ORM SME education through TSI
 - Recruit exposure via Delayed Entry and NSTC
 - Instructor development via CNL



Controls

Education and Training - Continued

- **Uncontrolled Risks**

- Funding for course development and updates
 - NKO Course updates
 - Instructor and Assessor modules needed
 - Leadership material standardization
- Perception of added training
 - Fleet is fearful of additional requirements on a full plate
 - ORM initiatives are perceived as “stand alone” training
 - Effort is to weave ORM into “how to teach” - not “teach ORM”



Controls

Assessment

- **Refining model assessment process**
 - NSC Safety Survey Teams using initial pilot process
 - Pilot assessments used at NAS Lemoore, NAS Whidbey Island, Ships at NP Norfolk
- **Partnering with Assessment Commands**
 - Exploring way ahead with Second and Third Fleet, Strike Force Training Groups, Tactical Training Groups, NSAWC



Controls

Feedback

- Currently limited to NSC Website and limited use of TRACS
- Feedback mechanisms are a Next Action item



Supervision

Additional Pieces of the Puzzle

- **Update ORM Instruction**
 - Principles gathered in Norfolk 27-29 June
 - **Goal:** VCNO signed instruction by 30 Sep 06
 - Will provide requirements and standardized approach to ORM
- **Strengthen Baseline Knowledge Level**
 - **Recommend** a force-wide review of NKO ORM training and documentation of completion
 - **Follows previous TYCOM directions**
 - **Added emphasis to current initiatives**



Supervision

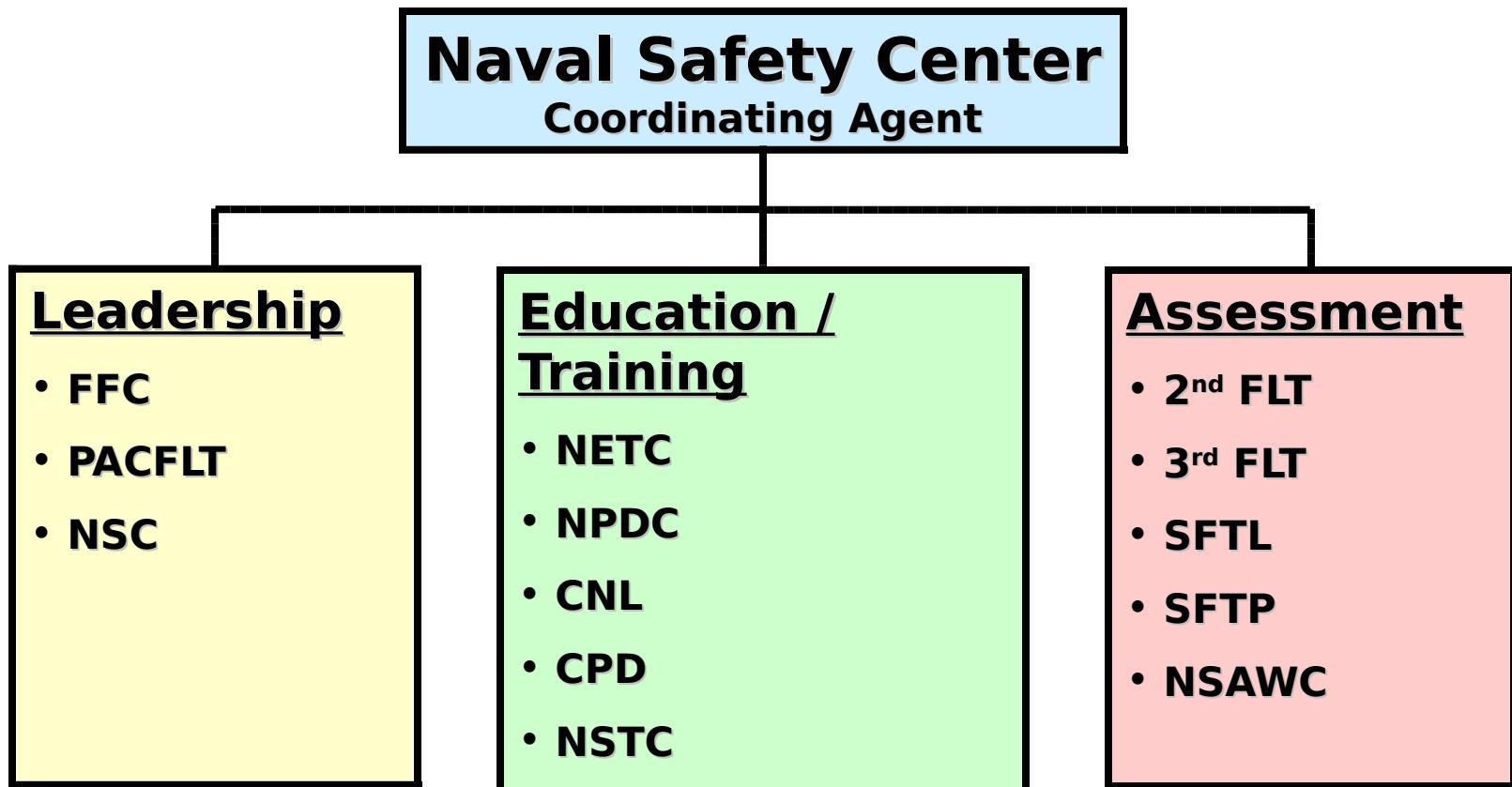
Additional Pieces of the Puzzle - Continued

- **Drive Toward Common Terminology**
 - A key piece to solving the puzzle
 - ***Recommend*** message from leadership to leadership emphasizing the importance of “visible ORM buy-in” through use of accepted ORM terms
 - Follow up will be standardization of terms in updated ORM instruction
- **Build a set of Time Critical ORM skills in our Sailors**
 - Merge the proven skills of CRM with ORM
 - Models considering include USCG and MV-22 Community



Supervision

Current Commands Engaged in ORM Revitalization



How We Get There

- **Leadership (FFC/CPF/NSC Leading)**
 - ISIC, CO, XO, DH, CMC acceptance and full understanding of ORM
 - Use of ORM terms by those in leadership positions
 - “By example” knowledge and application of principles - make it visible
 - Expectation of process use in all endeavors
- **Education and Training (NSC/NPDC Leading)**
 - A Safety Training Continuum (STC) with ORM/CRM as cornerstones
 - Focus ORM SME education on application, and assessment
 - Focus executive level education on principles, planning and process management
 - Build standardized expertise in evaluators and instructors
 - Revise and improve current ORM online and resident courses
- **Assessment (NSC/CSFTG Leading)**
 - Objectively review devotion to principles/application of process
 - Internal Assessments led by ORM Manager (XO)
 - External Assessments by established commands (NSC, ATG, CSFTG, etc.)
- **Feedback (NSC Leading)**
 - Feedback from assessment teams to leadership
 - Feedback from internal assessments to ISICs
 - Input to TRACS by all units
 - Feedback from NSC via web and TRACS



NESB Discussion



Tracking DON civilian mishaps



NESB Tasking

What is the feasibility of tracking civilian off-duty mishaps?



Feasibility of Tracking Civilian Off-Duty Mishaps

Injury

- **A civilian injured off-duty might bring a doctor's note requesting restricted/light duty. The note does not have to specify what the injury is.**

Motor Vehicle mishap

- **Civilians involved in an off-duty private motor vehicle (PMV) mishap have no legal duty to report this to the Navy.**



Feasibility of Tracking Civilian Off-Duty Mishaps

Conclusion

- **It is not feasible to collect off-duty injury or PMV mishap data on Navy civilians**
 - Privacy Act, 5 USC sec.522a (2000)



Navy POA&M Update



Navy POA&M Update

- **Purpose of brief:**
 - **Provide status of POA&M action items due Jun/Jul/Aug 06.**
 - **Request action commands provide updates and requested changes to NAVSAFECEN prior to next NESB Flag Panel meeting.**
- **Status**
 - **Task completed:** 
 - **Beyond due date, update required:** 
 - **Beyond due date and action not complete:** 



Navy POA&M Update

Obj #	Task #	Sub Task #	Task Description	Due date	Lead Command/ Agency	Supporting Commands/ Agencies	Amplification	Status
	1.12		IMPROVE DISSEMINATION OF TRAFFIC SAFETY & RECREATION/ OFF-DUTY BEST PRACTICES					
	1.12A		Establish a Traffic Safety & Recreation/Off-Duty best practices collection process and database and make available to DON users.	1-J ul-06	NSC		Subtask also supports 5.11.2.	
	1.16		ENGAGE NON-DON PARTNERS IN PMV MISHAP PREVENTION					
	1.16A		Direct Navy Regions to build strong mishap prevention partnership ties with community officials in high military population centers.	1-Aug-06	CNIC	NSC		
	1.18		CONDUCT A TRAFFIC SAFETY CAMPAIGN DURING PERIODS WHEN PMV MISHAPS ARE HISTORICALLY HIGHER					
	1.18A		Develop and disseminate a safe driving campaign package every year for use during the Memorial Day to Labor Day period.	1-May-06	NSC		Due date is 1 May of each year.	
1.2	1.2.1		IMPROVE REPORTING, DATA COLLECTION AND ANALYSIS OF HIGH LOST WORK TIME AREAS FOR BOTH NAVY CIVILIANS AND UNIFORMED					
	1.2.1A		Determine the specific data that will be used to identify key areas causing the highest civilian lost work time rates.	1-J ul-06	Ops Safety Spt Cmte (ESB)	NSC/ BUMED/ICPA s	Use installation-level data and "Pareto Principle" 80/20 rule to identify factors attributed to highest rates.	
1.3	1.3.1		IMPROVE DISSEMINATION OF MISHAP DATA AND PROGRESS ON MISHAP REDUCTION TO NAVY LEADERSHIP					
	1.3.1B		Obtain BUPERS permission to use their website for Flag Officers/SES's to share Safety Concerns / Issues.	1-J ul-06	NSC			
	1.7.3		RESEARCH, COLLECT AND STANDARDIZE BEST PRACTICE EFFORTS					
	1.7.3A		Develop a mechanism to collect Best Practices from Navy units and make the database accessible to units and personnel.	1-J un-06	NSC			
	1.7.3B		Direct the submission of safety best practices into the Navy's best practices database.	15-J un-06	TYCOMs		Best practices shall be submitted to the NSC best practices database.	



Navy POA&M Update

Obj #	Task #	Sub Task #	Task Description	Due date	Command/ Agency	Commands/ Agencies	Amplification	Status
	2.1.2 IMPROVE THE QUALITY OF CO/XO AND DEPARTMENT HEAD UNDERSTANDING OF THE ROLE OF SAFETY AND RISK MANAGEMENT							
	2.1.2A		Review and recommend improvements to the safety portion of PCO/PXO/Dept Head courses for all communities, as required.	1-Jun-06	Ops Safety Cmte Ops Safety Spt Cmte (ESB)			
	2.1.3 ASSESS ROLE OF OPERATIONAL RISK MANAGEMENT IN ORGANIZATIONAL CULTURE							
	2.1.3A		During command inspections conducted by ISICs, ensure safety, mishap prevention, and operational risk management are assessed and are part of the organizational culture.	1-Jun-06	Echelon 2s	Echelon 3s	Subtask also supports subtask 3.2.2B and Objective 3.3.	
	2.1.4 ENSURE MISHAP REDUCTION CAMPAIGN IS AN ALL HANDS EFFORT							
	2.1.4A		Ensure 75% mishap reduction campaign in support of the Naval Safety Strategy is briefed at all levels.	1-Jul-06	Echelon 2s	Echelon 3s		
2.5	2.5.1 ESTABLISH A NAVY EXECUTIVE SAFETY BOARD (ESB)							
	2.5.1A		Establish a Navy Executive Safety Board with associated committee structures.	1-May-06	OPNAV		Gain Flag level approval of Navy ESB structure.	
	2.5.1B		Write a charter for the Navy Executive Safety Board that includes its mission, function, responsibilities, and membership. Also delineate scope of activity and membership for its permanent committees.	1-Aug-06	NSC	Ops Safety Cmte/ Ops Safety Spt Cmte (ESB)		
3.3	3.3.1 CONTINUE TO DEVELOP, SUPPORT AND IMPLEMENT A SAFETY TRAINING CONTINUUM FOR ALL NAVY PERSONNEL							
	3.3.1F		Investigate status of Delayed Entry Program (DEP) Operational Risk Management training.	1-Jul-06	NETC/NSTC	OJ AG	Coordinate with HQMC SD.	
	3.3.2 ESTABLISH NECESSARY ORGANIZATIONAL RELATIONSHIPS TO SUPPORT THE SAFETY TRAINING CONTINUUM							
	3.3.2A		Review and revise as necessary relationship between NPDC and NAVOSHENVTRACEN/NSC.	1-Jul-06	NSC	NETC		



Navy POA&M Update

Obj #	Task #	Sub Task #	Task Description	Due date	Lead Command/ Agency	Supporting Commands/ Agencies	Amplification	Status
3.5	3.5.1		MORE CLOSELY ALIGN SAFETY IN THE ACQUISITION PROCESSES					
		3.5.1A	Ensure criteria for ESOH is in all applicable capabilities (J CIDS) documents; ICD, CPD, CDD and ORDs. (Initial capabilities documents-MS-A, Capabilities Development Documents- MS-B, Capabilities Design Documents - MS-C and legacy Operational Requirements	1-May-06	NSC (N09FB)		Central to mission and function of N09FB. (Support by System Safety Advisory Board / N1, N4, N7/N8, N09, N91/N93).	●
4.5	4.5.1		ESTABLISH POLICY AT THE BASE AND REGIONS TO ENSURE ACCOUNTABILITY FOR THE ENFORCEMENT OF TRAFFIC SAFETY REGULATIONS					
		4.5.1A	Require base police to report all "on-base only" traffic violations to service members/employee command.	1-Jul-06	CNIC	Navy Regions	Incorporate reporting requirement in CNIC Region Instructions. Pursue revision of OPNAVINST 5100.12G/H to include reporting requirement. Note: (Similar to HASP report).	●
5.1	5.1.1		IMPROVE THE CAPABILITIES/INTEGRATION OF THE WEB-ENABLED SAFETY SYSTEM					
		5.1.1B	Convene a Configuration Control Board to evaluate temporary term reduction of required data fields during the zero based review period.	1-Jun-06	NSC	Echelon 2s	Reduction in required data fields will increase mishap reporting in the near term by balancing need for mishap analysis and leading indicators with the burden of inputting data on the user.	●
	5.2.2		IMPROVE MISHAP AND HAZARD REPORTING ACCOUNTABILITY					
		5.2.2B	Revisit MIR/SIR and endorsement timelines and make changes, as required.	1-Jul-06	NSC	Echelon 2s		
6.3	6.3.1		LINK SAFETY EXPENDITURES TO EXPECTED BENEFITS THROUGH USE OF BUSINESS CASE ANALYSES					
		6.3.1C	Determine the process for allocating resources to safety initiatives with high ROI.	1-Jun-06	ESB	NSC	NSC draft process flow chart and obtain ESB approval.	●
6.7	6.7.1		MAKE PROGRAMATIC IMPROVEMENTS TO DON'S SAFETY PROFESSION					
		6.7.1B	Improve the expertise of Navy civilian and military safety personnel by implementing policies which promote and financially support professional certification, e.g. as Certified Safety Professionals (CSP) and Certified Industrial Hygienists (CIH).	1-Aug-06	NSC (N09F)	OPNAV N11/ BUMED	Monitor the number of certified safety professionals annually. Review OPNAVINST 5100.23G and 5100.19.	
6.9	6.9.1		MANDATE AND RESOURCE TRAFFIC SAFETY AND OFF-DUTY SAFETY PROGRAMS UNDER INSTALLATION SAFETY OFFICES					
		6.9.1A	Continue funding of current CNIC Traffic Safety and Recreation/Off-Duty programs/initiatives.	1-Jun-06	CNIC	NA	This subtask also supports Objective 1.1.	●



New Business



2006 DON Objectives



SECNAV, CNO and CMC 2006 DON Objectives

Top Five Department of the Navy Objectives for 2006:

#1 Optimize the Workforce

#2 Aggressively Prosecute GWOT

#3 Build USN/USMC Force for

Tomorrow

#4 *Emphasize Safety*

**#5 Reinforce Ethics as a Foundation of
Conduct**

***“Emphasize Safety. Manage risk to improve
mission effectiveness and to safeguard the
people and resources of the Navy-Marine Corps Team.”***



#4: Emphasize Safety

- ASN(I&E) tasked to develop short-term goals, actionable metrics and methodology for measuring progress.
- Goals/ Metrics: Should change as needed. Don't chase metrics that are no longer valid or trends we can't explain
 - What did we do/not do to make the numbers change?
- Less Aggregation - More drill down to ID who needs help
- How do we measure progress to know what is working and what is not?
- SECNAV approved plan and has asked for quarterly progress reports
- Safety Objectives to be included in USN/USMC POA&Ms supporting DON Safety Strategy
 - Updated Monthly
- DASN(S) to provide monthly update to ASN(I&E)
- Proposal to align DON Objectives to FY vice CY
 - Current 2006 Objectives to become FY07 DON Objectives



#4: Emphasize Safety: Three Sub Objectives

- **Secondary Objective 4.1:**
 - **Improve safety performance to meet Secretary of Defense Strategic Planning Guidance**
 - **(SPG) to reduce baseline mishap rates by 75% by the end of FY 2008.**
 - PMV Mishap Reduction
 - Aviation Mishap Reductions
 - Marine Corps Tactical Vehicle Mishap Reductions
 - Civilian Lost Day Rate Reduction
- **Secondary Objective 4.2:**
 - **Improve Data Collection, Utilization, Analysis and Distribution of Safety Information**
 - Assess current systems against Industry Standard for a RMIS
 - Develop a single DON-wide web based RMIS that will facilitate unit level safety program management and provide aggregate reporting, analysis and tracking of all reportable hazards and mishaps
- **Secondary Objective 4.3:**
 - **Maximize Department-wide Utilization of Risk Management Techniques**
 - Establish a risk management training continuum that targets specific training for given levels of responsibility to better institutionalize ORM both On- and Off-duty
 - Develop a Risk management Assessment tool to measure effectiveness of training



Navy FY06 Mishap Totals

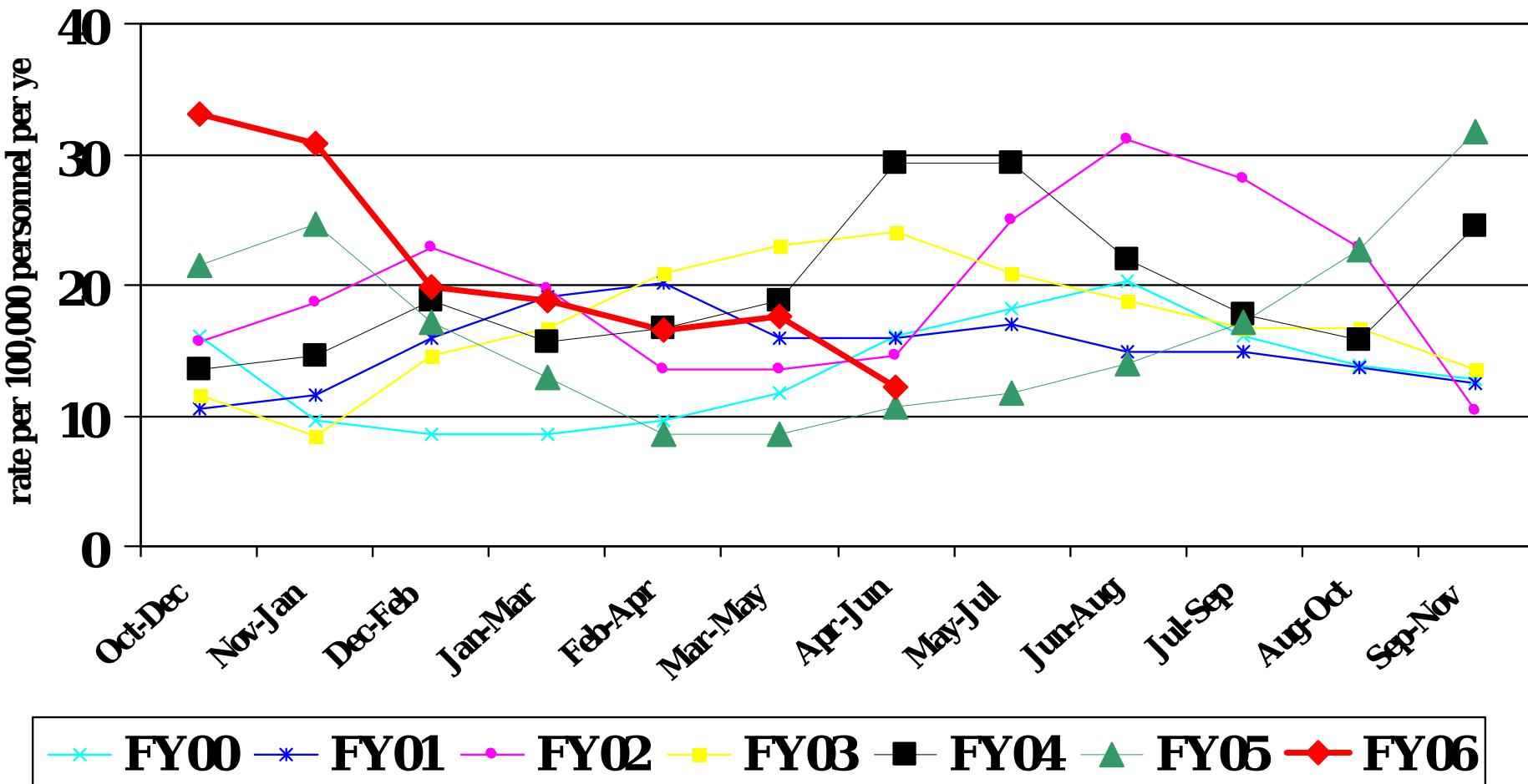


NESB Tasking

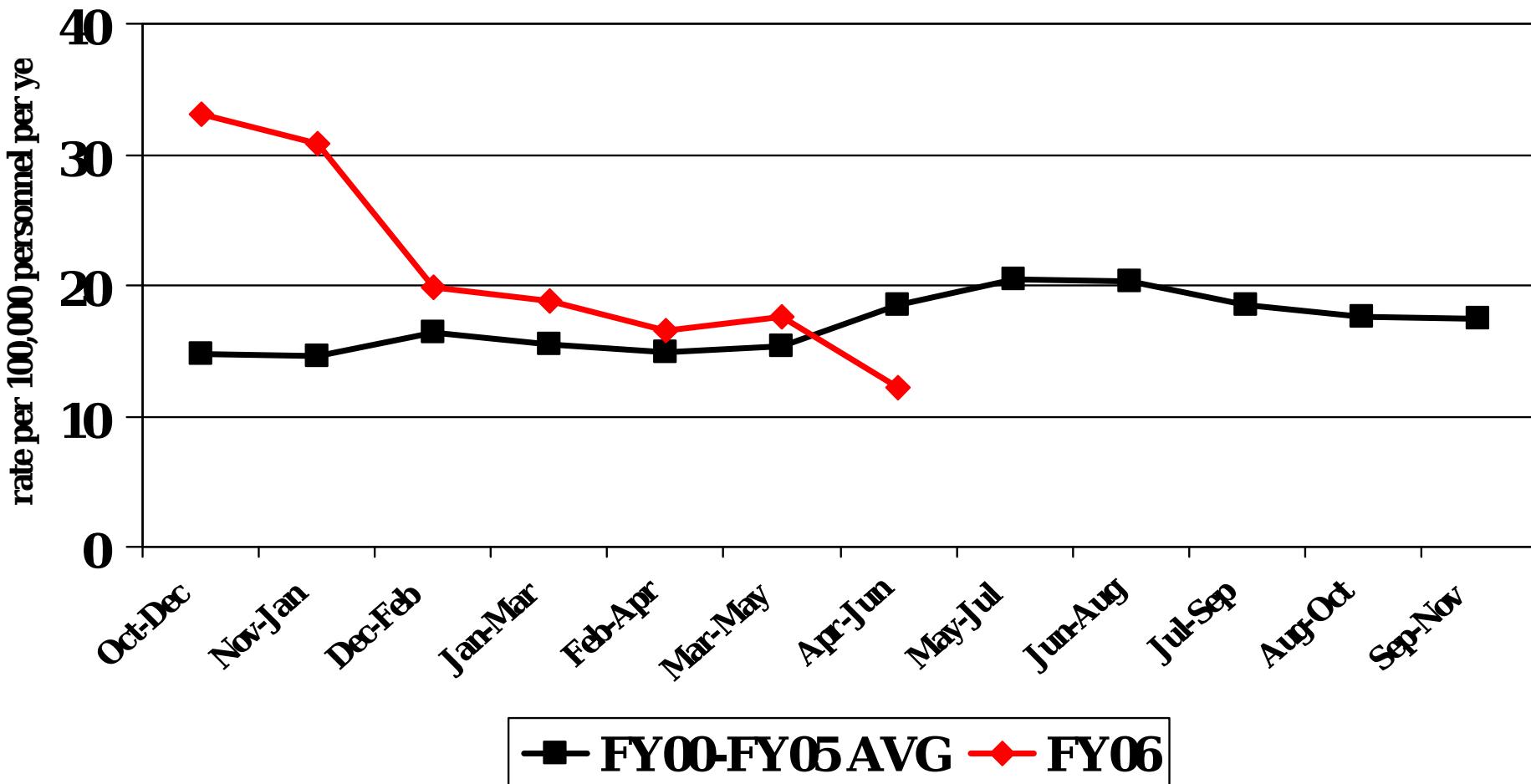
- Compare FY06 PMV fatality rolling average rate to PMV fatality rates from previous years



NAVY PMV 3-MONTH ROLLING AVERAGE

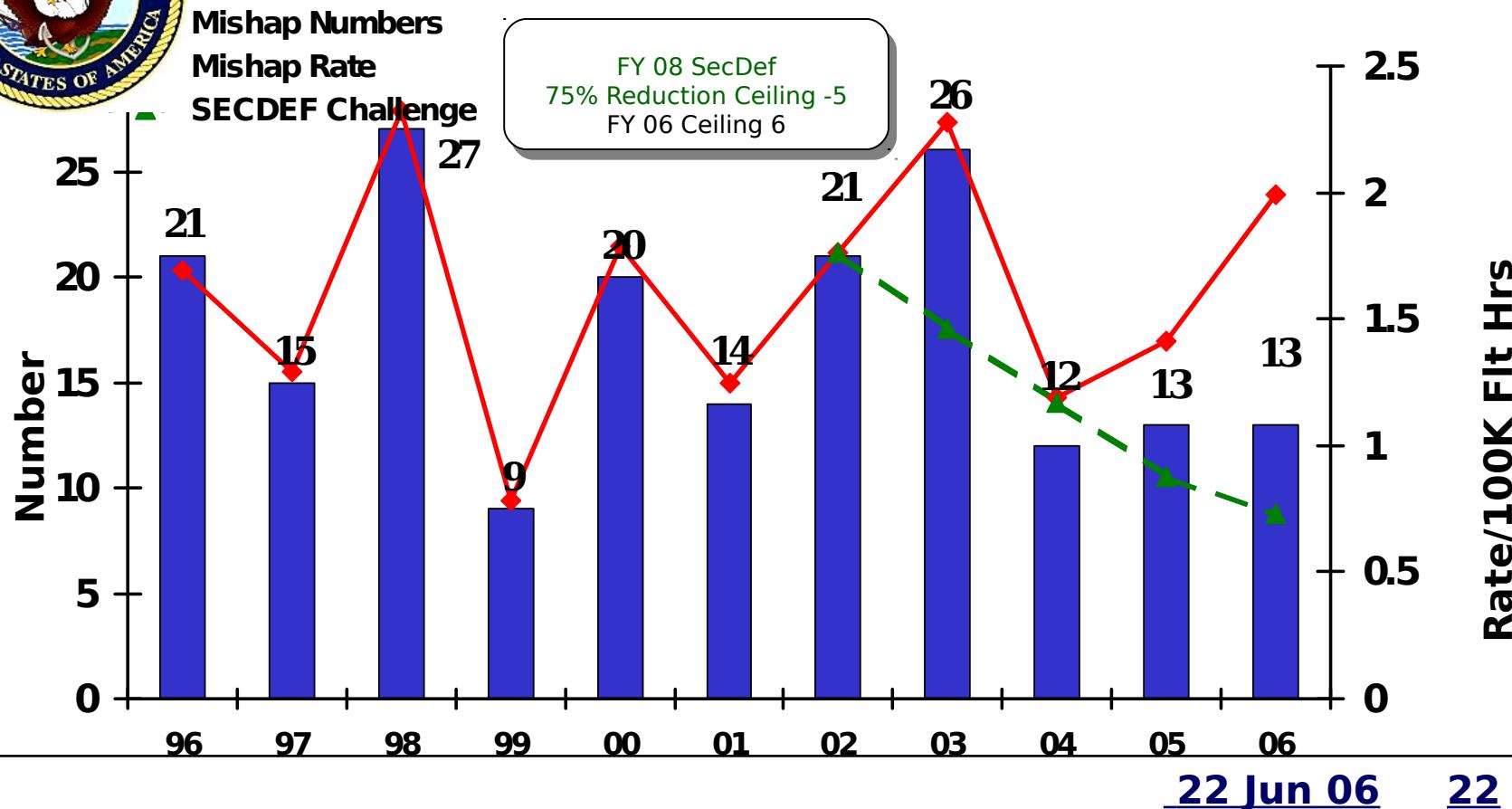


NAVY PMV 3-MONTH ROLLING AVERAGE





CLASS A FLIGHT MISHAPS



Jun 05

10 / 1.51

CLASS A FM/FM RATE FY COMPARISON: 13 / 1.99

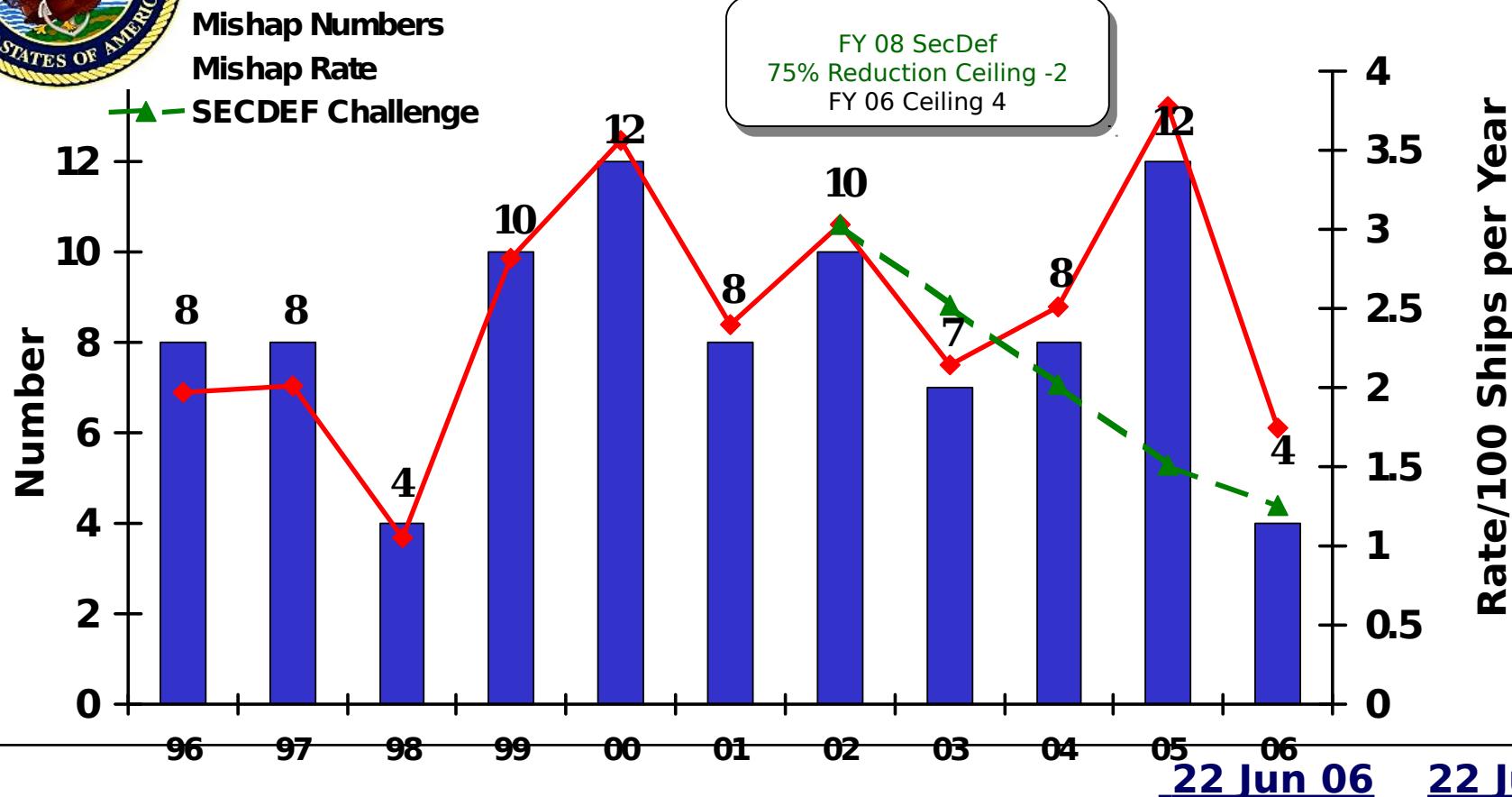
FY05 MISHAPS/MISHAP RATE: 13 / 1.41

10-YEAR AVERAGE (FY96-05) MISHAPS/MISHAP RATE: 17.8 / 1.59





CLASS A AFLOAT MISHAPS



05

1.73

CLASS A MISHAPS/MISHAP RATE FY COMPARISON:

4 / 1.74

4 /

FY05 MISHAPS/MISHAP RATE: 12 / 3.78

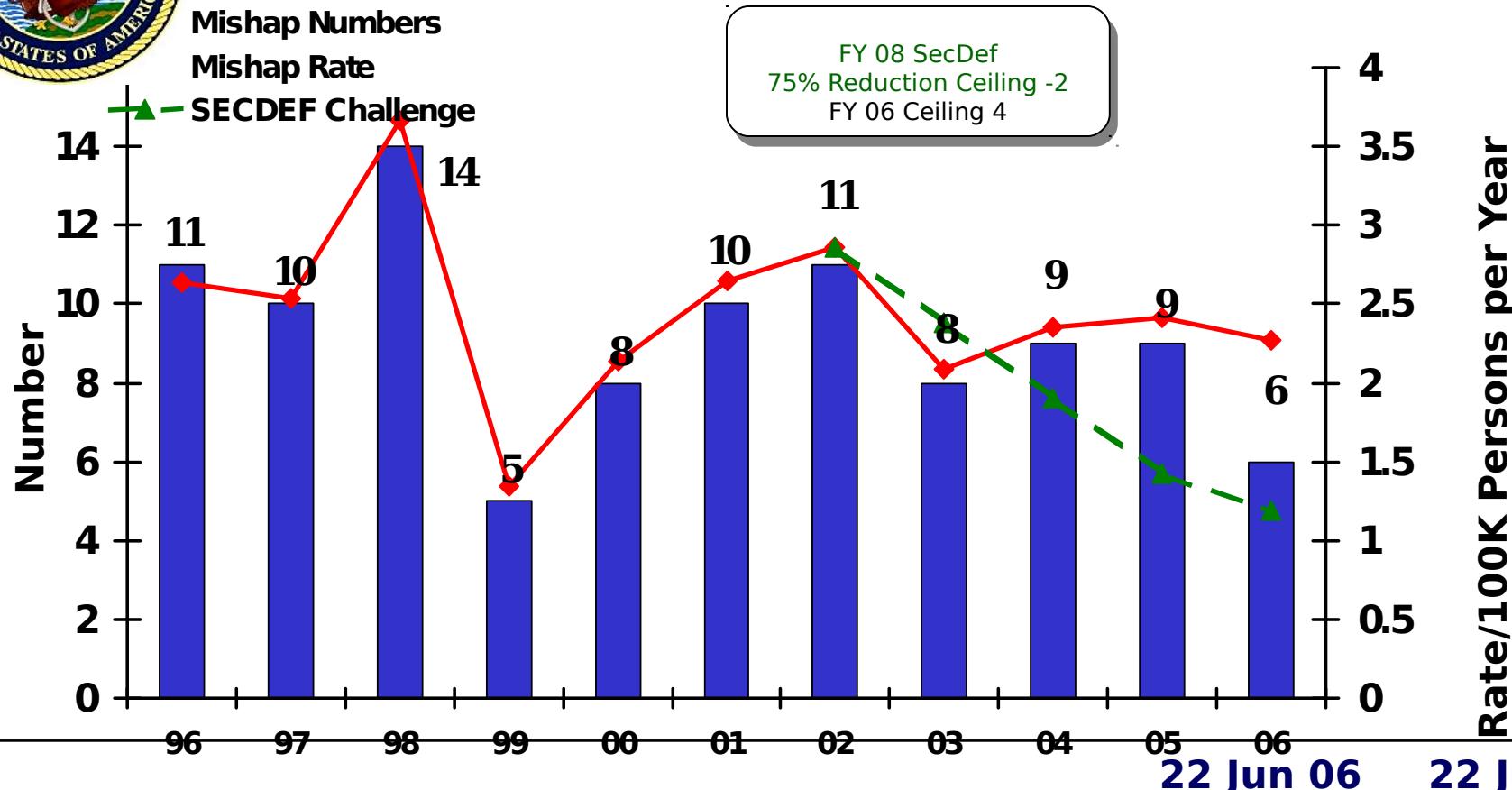
10-YEAR AVERAGE (FY96-05) MISHAPS/MISHAP RATE:

8.7 / 2.49





CLASS A SHORE OPER MISHAPS



05

CLASS A MISHAPS/MISHAP RATE FY COMPARISON:

2.21

6 / 2.27

6 /

FY05 MISHAPS/MISHAP RATE: 9 / 2.41

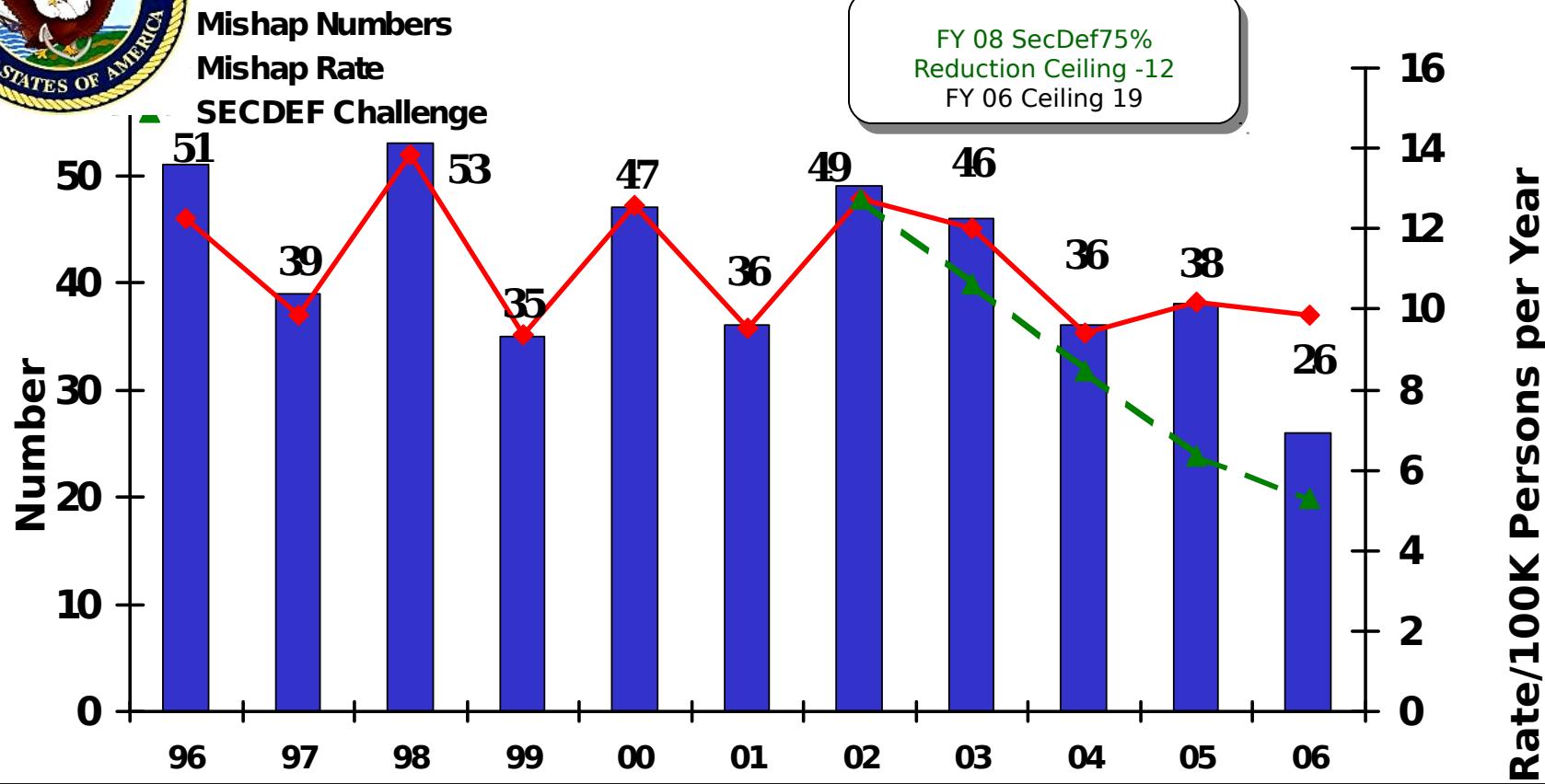
10-YEAR AVERAGE (FY96-05) MISHAPS/MISHAP RATE:

9.5 / 2.47





CLASS A OPER MISHAPS



05

8.47

CLASS A MISHAPS/MISHAP RATE FY COMPARISON:

26 / 9.84

23 /

FY05 MISHAPS/MISHAP RATE: 38 / 10.18

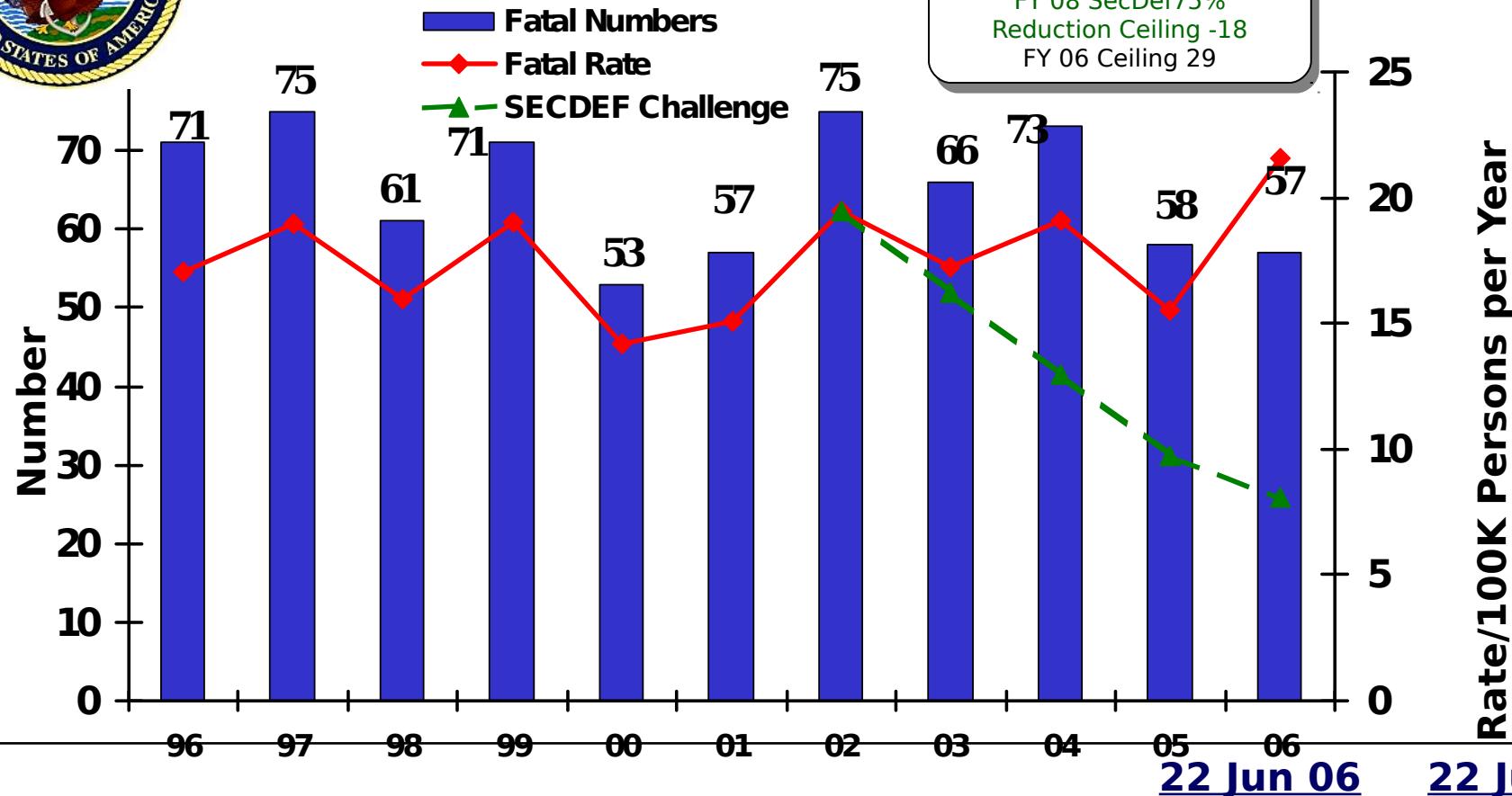
10-YEAR AVERAGE (FY96-05) MISHAPS/MISHAP RATE:

43.0 / 11.19





PMV FATALITIES



05

CLASS A FATALITIES/FATALITY RATE FY COMPARISON: 57 / 21.58 41 / 15.10

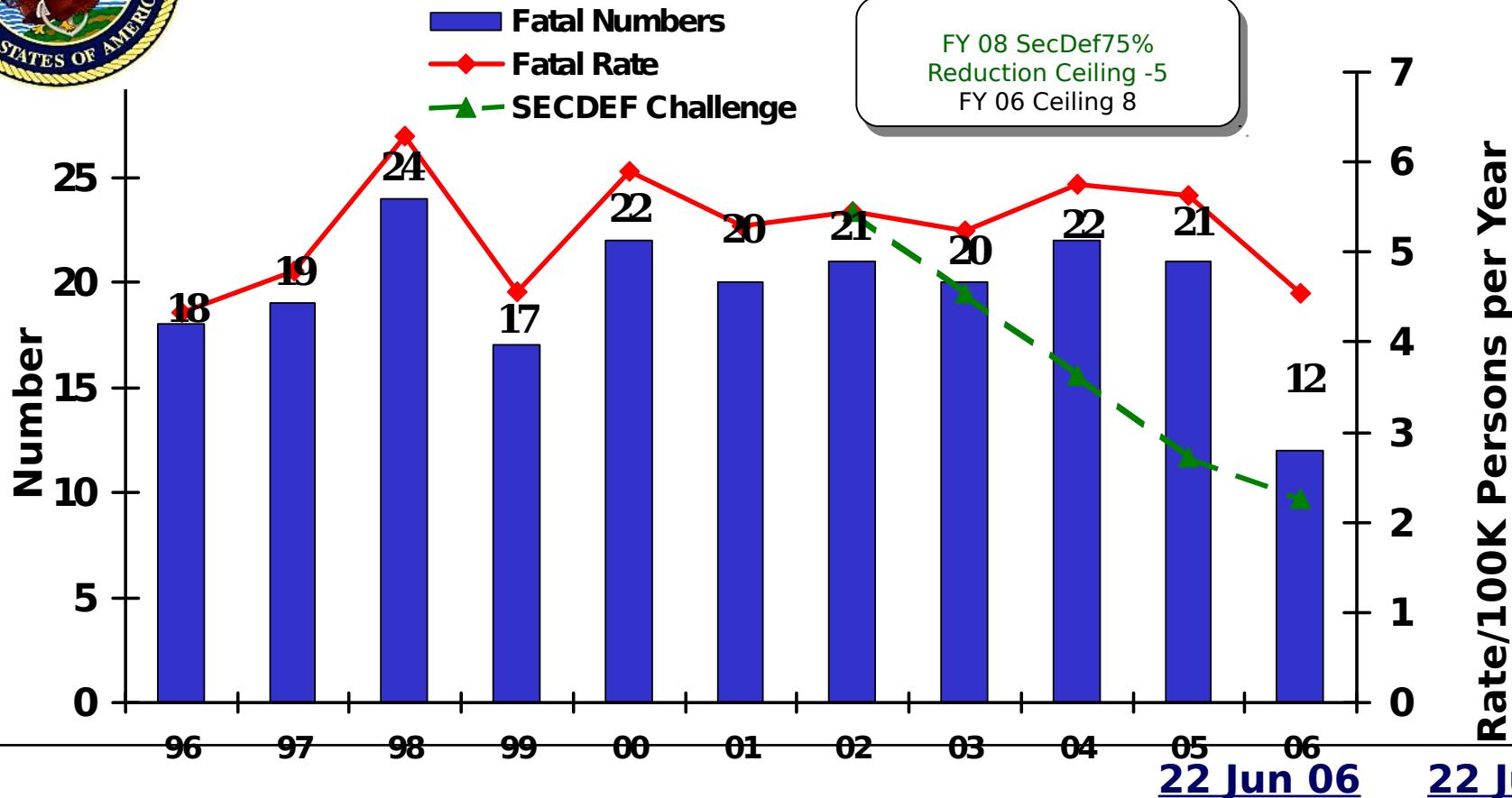
FY05 FATALITIES/FATALITY RATE: 58 / 15.5427

10 YEAR AVERAGE (FY96-05) FATALITIES/FATALITY RATE: 66.0 / 17.18





OFF-DUTY/REC FATALITIES



05

CLASS A FATALITIES/FATALITY RATE FY COMPARISON: 12 / 4.54 14 / 5.15

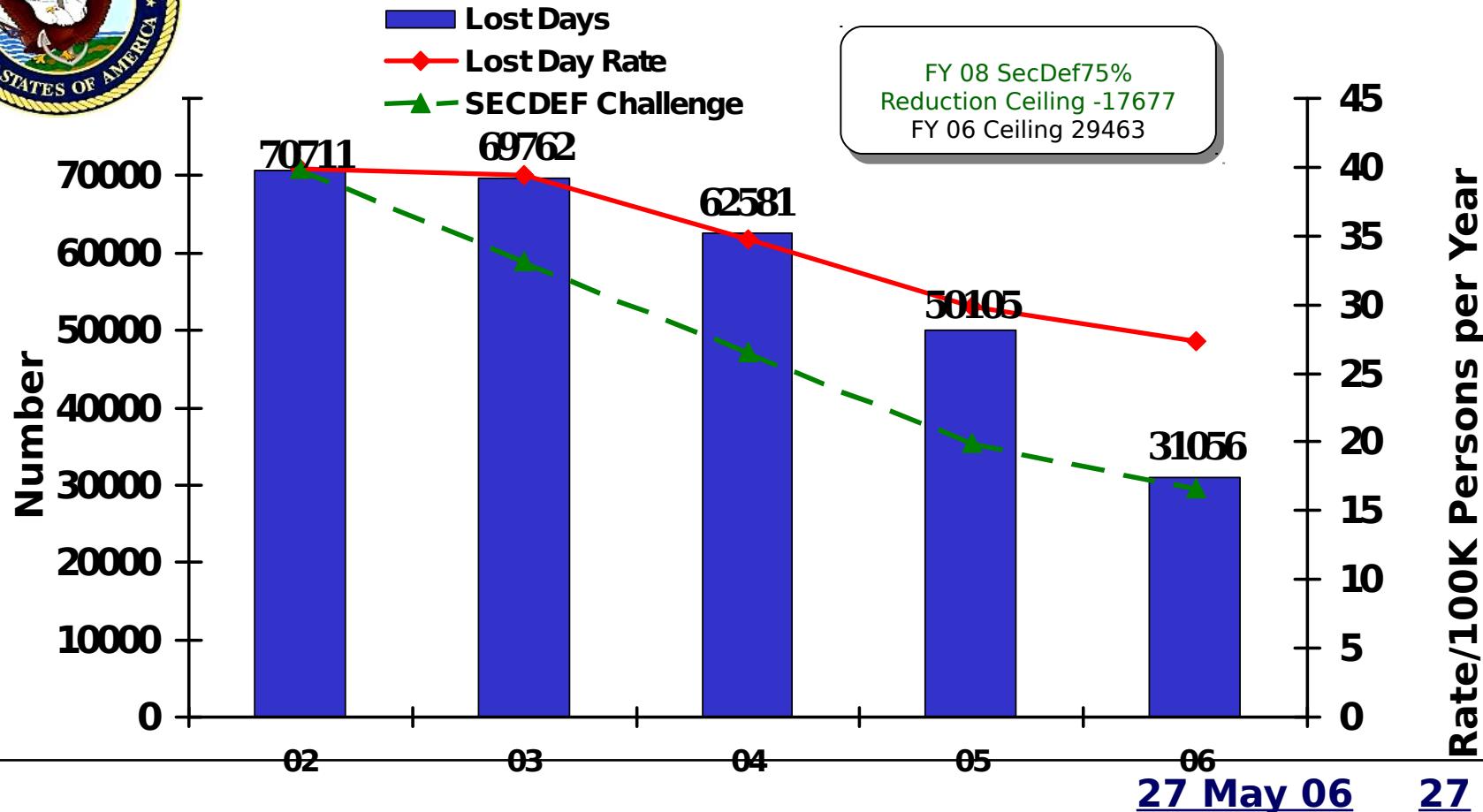
FY05 FATALITIES/FATALITY RATE: 21 / 5.63

10 YEAR AVERAGE (FY96-05) FATALITIES/FATALITY RATE: 20.4 / 5.31





CIVILIAN LOST WORK DAY



May 05

29.48

LOST WORK DAY FY RATE COMPARISON: 27.29

FY05 LOST WORK DAY RATE: 29.89

4-YEAR AVERAGE (FY02-05) LOST WORK DAY RATE: 36.03



NESB Discussion



CNO Tasking

- Develop and disseminate safety goals for the remainder of the FY and set the stage for next FY.
 - Action: NAVSAFECEN, assist from stakeholders
- Determine the number of flight hours required to achieve a better mishap rate than last FY.
 - Action: NAVSAFECEN, assist from CNAF
- Provide additional details on aviation material failure causal factors.
 - Action: CNAF, assist from NAVSAFECEN and NAVAIR
- Provide root causes for PT/PRT deaths.
 - Action: BUMED, assist from NAVSAFECEN and NPC



Closing Comments

